Exhibit 1: Model Individual Enrollment Form ("Election" may also be used) (4 Pages)

Medicare +Choice Plan Name: _____

Your Name: _____ **Your Medicare Number:** _____
Date of Birth (month/day/year): _____ **Male** ____ **Female** ____

Permanent Residence Address:

_____
Number, Street, Apartment #

_____ _____ ____ _____
City County State Zip Code

Telephone Number: _____ _____
Area Code Number

Mailing Address (if different from permanent address)

_____ _____ _____ ____ _____
Number, Street, Apartment # City County State Zip Code

Name of person to contact in case of emergency [Optional field] _____
Phone Number: [Optional field]_____ **Relationship to You** [Optional field]__

[Optional field] **Please check one of the boxes below if you would prefer us to send you information in a language other than English:**
___ Language A (e.g., Chinese) ___ Language B (e.g., Spanish)

Medicare Information:

Please fill in these blanks so they look the same as what is on your Medicare card. You need to fill this out, or you can attach a copy of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board.

We cannot call this enrollment form "finished" until you have given us this information.

Medicare Health Insurance
Social Security Act

Name of Beneficiary: _____

Medicare Claim Number Sex
___ - __ __ - __ __ __ __ ___

Is Entitled To Effective Date
__ Hospital Insurance (Part A) _____
__ Medical Insurance (Part B) _____

Your Medicare +Choice plan choice :_____

Please check which product you want to enroll in: [Optional field for plans with 1 product]

___ Product ABC [optional] Premium = $XX per month

___ Product XYZ [optional] Premium = $XX per month

Name of chosen Primary Care Physician (PCP), clinic or health center (if required):
[This field is not necessary for PPOs] _____

Release of Information: By joining this plan, I allow the Centers for Medicare and Medicaid Services to give information to the plan. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B). I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give CMS or CMS's agents the information needed to run the Medicare program.

Lock-In: I understand that, beginning on the date Medicare +Choice plan coverage begins, I must get all of my health care from the Medicare +Choice plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. In addition to being covered in the United States, emergency and urgently needed services are covered in certain hospitals in Mexico and Canada. I understand that services authorized by the Medicare +Choice organization and other services contained in my Medicare +Choice plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. I also understand that without authorization, NEITHER MEDICARE NOR THE MEDICARE+CHOICE PLAN WILL PAY FOR THE SERVICES. [Note: POS and PPO plans need to add a statement regarding financial liability when using non-contracted providers]

I understand that my signature on this application means that I have read and understand the contents of this application. Please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage with this Medicare +Choice plan.

Your Signature* _____ Date: _____

*If the individual cannot sign, a court-appointed Legal Guardian or person with Durable Power of Attorney for Health Care (DPAHC), if authorized by state law; or another person who is authorized by State law, must sign the following line. **Attach a copy of proof of Legal Guardian, DPAHC, or proof of authorization by state law**

Signature _____ Date: _____

*If anyone helped the individual fill out this form, s/he must sign the following line:
Signature _____ Date: _____ Relationship to Individual: _____

Please read and answer these questions:

1. Do you have End Stage Renal Disease (ESRD)? ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive.

   Yes _____ No _____

Note: If you have ESRD, you can not enroll in this plan unless you are already enrolled in the Medicare+Choice organization as a commercial member or you were affected by the non-renewal of another Medicare+Choice plan after December 31, 1998. If you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing you don't need dialysis or have had a successful kidney transplant.

2. Have you recently moved into this plan's service area?
   Yes _____ No _____

3. Have you changed your Medicare coverage other than during the past 6 months?
   Yes _____ No _____

Your answer to the following questions will <u>not</u> keep you from enrolling in this plan.

4. Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)?

   Yes _____ No _____
   If yes, Name of Institution _____
   Address of Institution (number and street) _____
   Phone Number of Institution _____
   Your Date of Admission into Institution _____

5. Do you receive Medicaid benefits?
   Yes_____ (If yes, Medicaid Number:_____) No _____

6. Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation, or VA benefits?

   Yes _____ No _____
   If yes, what kind of insurance do you have? _____
   What is the name of your insurance? _____

7. Do you or your spouse work?
   Yes _____ No _____

Please read these sentences and put your initials next to them:

1. I understand that while the "effective date of coverage" on the first page of this form is when I should begin using the plan's services, the plan will still send me final approval of my enrollment in the plan. I understand that I should not disenroll from **any Medicare supplement plan or Medigap/Medicare Select plan** until I get that approval from the plan. _____ (Initials)

2. I understand that I must keep my **Medicare Part A and Part B insurance** by paying the Part B premiums and the Part A premiums, if applicable. _____ (Initials)

3. I understand that I can be a member of only **one Medicare+Choice plan at a time**. By enrolling in this plan, I will automatically be disenrolled from any other Medicare+Choice plan of which I am currently a member. _____ (Initials)

4. I understand that since I can be a member of only one Medicare +Choice plan at a time, I **cannot enroll in more than one Medicare +Choice plan** with the same effective date of coverage. If I do this, my enrollments will be cancelled and I will have to fill out a new enrollment form to become a member of the Medicare +Choice plan. _____ (Initials)

5. I understand that, in general, I can change health plans or return to the Original Medicare Plan only during **certain times of the year**. _____ (Initials)

6. I understand that, in general, there are limitations to the **number of times** I can change my health plan choices during the year. _____ (Initials)

7. I understand that I may **disenroll** from this plan by sending a written request to the plan, the Social Security Office, the Railroad Retirement Board, or by calling 1-800-MEDICARE (TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). Until the effective date of disenrollment, I must keep getting health care from the plan doctors. _____ (Initials)

8. I understand that as a member of the plan, I have the right to **ask about the plan's decision** about payment or services if I disagree. _____ (Initials)

9. I understand that it is my job to tell the plan before I **move** out of the service and/or continuation area. I understand that if I move permanently out of the service and continuation area, Medicare requires the plan to disenroll me. _____ (Initials)

Office Use Only:
Plan ID #:_____
Effective Date of Coverage:_____
ICEP:_____ OEP:_____ AEP:_____ SEP(type):_____

Exhibit 3: Model Short Enrollment Form ("Election" may also be used) (2 Pages)
This form may be used in place of the model individual enrollment form when a member of a M+C plan is enrolling into another M+C plan in the same M+CO

If you are changing plans within {M+CO name} you should use this form. This form may not be used to enroll in {M+CO name} for the first time.

Name of Plan You are Enrolling In: _____

Name: _____ **Medicare Number:**_____
{Note: may use "member number" instead of "Medicare number"}

Permanent Address:

_____ _____ _____ _____ _____
Number, Street, Apartment # City County State Zip Code

Telephone Number: _____ _____
Area Code Number

Mailing Address (if different from permanent address)

_____ _____ _____ _____ _____
Number, Street, Apartment # City County State Zip Code

Please fill out the following:

I am currently a member of the _____ plan in {M+CO name} with a monthly premium of $_____ _____ .

I would like to change to the _____ plan in {M+CO name}. I understand that this plan has different health benefits and a monthly premium of $ _____ .

Have you recently **moved** into this plan's service area? Yes_____ No_____

Have you **changed** your Medicare coverage in the past 6 months? Yes _____ No _____

Optional field, if M+CO will require the member to name a new PCP:
Name of chosen Primary Care Physician (PCP), clinic or health center (if required):
_____

Release of Information: By joining this plan, I allow the Centers for Medicare and Medicaid Services to give information to the plan. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B). I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give CMS or CMS's agents the information needed to run the Medicare program.

Lock-In: **I understand that, beginning on the date my Medicare+Choice plan coverage begins, I must get all of my health care from my new Medicare+Choice plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. In addition to being covered in the United States, emergency and urgently needed services are covered in certain hospitals in Mexico and Canada. I understand that services authorized by the Medicare+Choice plan and other services contained in my Medicare+Choice plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. I also understand that without authorization, NEITHER MEDICARE NOR THE MEDICARE+CHOICE PLAN WILL PAY FOR THE SERVICES.** [Note: POS and PPO plans need to add a statement regarding financial liability when using non-contracted providers]

I understand that, in general, I can **change my health plans** or return to the Original Medicare Plan only during **certain times of the year** and that there are limitations to the **number of times** I can change my health plan choices during the year.

I understand that my signature on this application means that I have read and understand the contents of this application. Please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage with the Medicare +Choice plan.

Enrollee's Signature* _____ Date: _____

*If the individual is unable to sign, a court-appointed Legal Guardian or person with Durable Power of Attorney for Health Care (DPAHC), if authorized by state law, must sign the following line. **Attach a copy of the proof of Legal Guardian, DPAHC, or proof of authorization by state law**

Signature _____ Date: _____

*If anyone helped the beneficiary fill out this form, s/he must sign the following line:

Signature _____ Date: _____ Relationship to Beneficiary: _____

Office Use Only:
Plan ID #:_____
Effective Date of Coverage:_____
ICEP:_____ OEP:_____ AEP:_____ SEP(type):_____

Exhibit 4: Model Notice to Acknowledge Receipt of Completed Enrollment Form

Referenced in section(s): 4.4.1, 6.4

Dear <Name of Member>:

Thank you for filling out a form to enroll in <Plan name>. Starting <effective date>, you must see your <Plan> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, or out-of-area dialysis services, must be given or arranged by a <Plan> doctor(s). You will need to pay our copayments when you get health care. *Optional language:* This letter can serve as evidence of insurance until you get your member card from us. Until you get a member card from us, you should show this letter to your doctor when you go to your doctor appointments.

All enrollments have to be reviewed by the Center for Medicare and Medicaid Services (CMS), the federal agency that runs the Medicare program. We will send your enrollment to CMS, and they will do a final review of the enrollment. When CMS finishes its review, we will send you a letter to confirm your enrollment with <Plan>. But, you should not wait to get this letter before you begin using <Plan> doctors. You should begin using <Plan> doctors on <effective date>. Also, you should not cancel any Medigap/Medicare Select or supplemental insurance that you have until we send you the letter.

You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of <Plan>. If you do not have Medicare Parts A and B, we will bill you for any health care you receive from us, and neither Medicare nor <Plan> will pay for those services. Also, if you have end stage renal disease (ESRD), you may not be able to be a member of <Plan>, and we may have to send you a bill for any health care you received.

Please remember that, except for emergency or out-of-area urgent care, or out-of-area dialysis services**,** if you get health care from a non-<Plan> doctor without prior authorization, you will have to pay for the health care yourself.

** Insert information instructing member in simple terms on how to select a primary care provider/site (PCP); how to obtain M+C Plan services, e.g., provide the name, phone number, and location of the PCP, include the membership identification card when possible, explain unique POS and/or PPO procedures (when applicable), explain which services do not need PCP approval (when applicable), etc. **

If you have any questions, please call our Member Services Department at <phone number> or, for the hearing impaired, at <TDD/TTY number>. We are open {insert days/hours of operation and, if different, TTY/TDD hours of operation }. Thank you.

Exhibit 5: Model Notice to Request Information

Referenced in section(s): 4.2.2

Dear <Name of Beneficiary>:

Thank you for your application to <M+C Plan>. We cannot process your application until we get the following things from you:

_____ Proof of Medicare Part A and B coverage. You can send us a copy of your Medicare card or a letter from Social Security or the Railroad Retirement Board as evidence of your Medicare coverage.

_____ A copy of your legal papers authorizing another person to act on your behalf.

_____ Other: _____

You will need to send this information to <M+C Plan name and address> by <date - 30 days from date letter provided to the beneficiary>. If you cannot send this information by <date listed above>, we will have to deny your request to enroll in our plan.

If you have any questions, please call our Member Services Department at <phone number> or, for the hearing impaired, at <TDD/TTY number>. We are open <insert days and hours of operation>. Thank you.

Exhibit 6: Model Notice to Confirm Enrollment

Referenced in section(s): 4.4.2, 4.6

Dear <Name of Member>:

This letter is to tell you that the Centers for Medicare and Medicaid Services, the federal agency that runs Medicare, has approved your enrollment in <M+C Plan>, beginning <effective date>.

As we said in a letter we gave you before, now that your enrollment is confirmed, you may cancel any Medigap or supplemental insurance that you have.

Please feel free to call our Member Services at <phone number> or, for the hearing impaired, at <TDD/TTY number> if you have any questions. We are open <days and hours of operation>.

Exhibit 7: Model Notice for M+CO Denial of Enrollment

Referenced in section(s): 4.2.3

Dear <Name of Beneficiary>:

Thank you for applying for membership in <M+C Plan>. We cannot accept your application for enrollment in <M+C Plan> because:

1. _____ You do not have Medicare Part A

2. _____ You do not have Medicare Part B

3. _____ You have End Stage Renal Disease (ESRD)

4. _____ Your permanent residence is outside our service or continuation area

5. _____ We did not receive the information we requested from you within 30 days of our request.

6. _____ You are not eligible to enroll in another Medicare+Choice plan at this time. You will be able to change your health plan choice during the Annual Election Period in November with an effective date of January 1, <insert year>.

Medicare MSA plans add #7:

7. _____ National enrollment in Medicare Medical Savings Accounts has reached the maximum amount allowed under law

{*This paragraph is optional for M+C plans that do not send notice prior to this letter instructing the individual to use plan services as of a certain date.}* If we checked item 1 or 2, and it is correct, then we will send you a bill for any services you received. If we checked anything else and it is correct, then we may send you a bill for any services you received.

If what we checked is wrong, or if you have any questions, please call us at <phone number> or, for the hearing impaired, at <TDD/TTY number>. We are open <insert days and hours of operation>. Thank you.

Exhibit 8: Model Notice for CMS Rejection of Enrollment

Referenced in section(s): 4.4.2

Dear <Name of Beneficiary>:

Thank you for your recent application to <M+C Plan>. We are sorry to say that the Centers for Medicare and Medicaid Services, the federal agency that runs Medicare, has denied your enrollment in <M+C Plan> due to the reason(s) checked below:

1. _____ You do not have Medicare Part A

2. _____ You do not have Medicare Part B

3. _____ You have End Stage Renal Disease (ESRD)

4. _____ You signed a form to enroll in a different plan for the same effective date, which canceled your application with <M+C Plan>. This may mean that you are still enrolled in the Original Medicare Plan or in the Medicare+Choice plan that you were enrolled in before you applied for membership in our plan.

5. _____ You are not eligible to enroll in another Medicare+Choice plan at this time. You will be able to change your health plan choice during the Annual Election Period in November with an effective date of January 1st <insert year>.

If we checked number 1 or 2, and it is right, then we will send you a bill for any services you received from us.

If we checked number 3 or 4, and it is right, then we may send you a bill for any services you received from us.

If what we checked is not right, or if you have any questions, please call us at <phone number> or, for the hearing impaired, at <TDD/TTY number>. We are open <insert days and hours of operation>. Thank you.